

		FOR OFF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0042135</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Bethany Health Care & Rehab Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2005</u> to <u>12/31/2005</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>3298 Resource Parkway</u> <u>Dekalb</u> <u>60115</u>		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Dekalb</u>			
Telephone Number: <u>815-756-5526</u> Fax # ()			
IDPA ID Number: <u>43-1776735</u>			
Date of Initial License for Current Owners: <u>1/28/1998</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY,NON-PROFIT			
<input type="checkbox"/> Charitable Corp.			
<input type="checkbox"/> Trust			
IRS Exemption Code _____			
<input checked="" type="checkbox"/> PROPRIETARY			
<input type="checkbox"/> Individual			
<input type="checkbox"/> Partnership			
<input checked="" type="checkbox"/> Corporation			
<input type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
<input type="checkbox"/> GOVERNMENTAL			
<input type="checkbox"/> State			
<input type="checkbox"/> County			
<input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact:			
Name: <u>Ken Marx, BKD,LLP</u>			
Telephone Number: <u>314-231-5544</u>			
		Officer or Administrator of Provider	
		(Signed) _____ (Date) _____	
		(Type or Print Name) <u>Clark Ribordy, THCSLLC, Mgt. Co.</u>	
		(Title) _____	
		(Signed) _____ (Date) _____	
		Paid Preparer	
		(Print Name and Title) _____	
		(Firm Name & Address) _____	
		(Telephone) () Fax # ()	
		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	

Facility Name & ID Number Bethany Health Care & Rehab Center

0042135 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>90</u>	Skilled (SNF)	<u>90</u>	<u>32,850</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>90</u>	TOTALS	<u>90</u>	<u>32,850</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>15,222</u>	<u>9,614</u>	<u>4,829</u>	<u>29,665</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,222</u>	<u>9,614</u>	<u>4,829</u>	<u>29,665</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 90.30%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

N/A - None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?

YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 11/4/1997

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 11/4/1997 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 90 and days of care provided 4,829

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Bethany Health Care & Rehab Center # 0042135 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	223,703	10,627	9,759	244,089		244,089	(2,241)	241,848			1
2	Food Purchase		161,449		161,449		161,449	(778)	160,671			2
3	Housekeeping		10,849	80,374	91,223		91,223		91,223			3
4	Laundry		12,176	53,582	65,758		65,758		65,758			4
5	Heat and Other Utilities			119,504	119,504		119,504		119,504			5
6	Maintenance	38,438	12,361	88,319	139,118		139,118		139,118			6
7	Other (specify):*											7
8	TOTAL General Services	262,141	207,462	351,538	821,141		821,141	(3,019)	818,122			8
	B. Health Care and Programs											
9	Medical Director			24,647	24,647		24,647		24,647			9
10	Nursing and Medical Records	1,513,299	91,974	18,588	1,623,861		1,623,861		1,623,861			10
10a	Therapy		2,236	474,376	476,612		476,612		476,612			10a
11	Activities	56,992	3,592	5,960	66,544		66,544		66,544			11
12	Social Services	59,306	889	2,012	62,207		62,207		62,207			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,629,597	98,691	525,583	2,253,871		2,253,871		2,253,871			16
	C. General Administration											
17	Administrative	70,838			70,838		70,838		70,838			17
18	Directors Fees											18
19	Professional Services			287,135	287,135		287,135		287,135			19
20	Dues, Fees, Subscriptions & Promotions			55,158	55,158		55,158	(32,413)	22,745			20
21	Clerical & General Office Expenses	149,841	28,108	67,694	245,643		245,643	(83,676)	161,967			21
22	Employee Benefits & Payroll Taxes			291,614	291,614		291,614		291,614			22
23	Inservice Training & Education			574	574		574		574			23
24	Travel and Seminar			14,574	14,574		14,574		14,574			24
25	Other Admin. Staff Transportation			9,275	9,275		9,275		9,275			25
26	Insurance-Prop.Liab.Malpractice			81,533	81,533		81,533		81,533			26
27	Other (specify):*											27
28	TOTAL General Administration	220,679	28,108	807,557	1,056,344		1,056,344	(116,089)	940,255			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,112,417	334,261	1,684,678	4,131,356		4,131,356	(119,108)	4,012,248			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			116,005	116,005		116,005		116,005			30
31	Amortization of Pre-Op. & Org.			11,531	11,531		11,531	(11,531)				31
32	Interest			282,930	282,930		282,930	(579)	282,351			32
33	Real Estate Taxes			107,000	107,000		107,000		107,000			33
34	Rent-Facility & Grounds							7,725	7,725			34
35	Rent-Equipment & Vehicles			2,101	2,101		2,101	1,420	3,521			35
36	Other (specify):*											36
37	TOTAL Ownership			519,567	519,567		519,567	(2,965)	516,602			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		178,998	16,125	195,123		195,123		195,123			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,275	49,275		49,275		49,275			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		178,998	65,400	244,398		244,398		244,398			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,112,417	513,259	2,269,645	4,895,321		4,895,321	(122,073)	4,773,248			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Bethany Health Care & Rehab Center # 0042135 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,241)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(579)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(778)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(36,246)	21		24
25	Fund Raising, Advertising and Promotional	(32,413)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(4,984)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (77,241)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense	(11,531)	31	33
34	Adjustments for Related Organization Costs (Schedule VII)	(33,301)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (44,832)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (122,073)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Miscellaneous Income	\$ (4,984)	21
2			
3			
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49	Total	(4,984)	

Summary A

12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Summary B

Facility Name & ID Number	Bethany Health Care & Rehab Center	#	0042135	Report Period Beginning:	01/01/2005	Ending:	12/31/2005
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Tutera Health Care Services, LLC	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Building and Fixtures	\$	Tutera Health Care Services, LLC	100.00%	\$ 7,725	\$ 7,725	1
2	V	35	Moveable Equipment		Tutera Health Care Services, LLC	100.00%	1,420	1,420	2
3	V	21	Non-Capital	210,130	Tutera Health Care Services, LLC	100.00%	167,684	(42,446)	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 210,130			\$ 176,829	\$ * (33,301)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Bethany Health Care & Rehab Center # 0042135 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Bethany Health Care & Rehab Center # 0042135 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Tutera Health Care Services, LLC
Street Address 7611 State Line Road, Suite 301
City / State / Zip Code Kansas City, MO 64114
Phone Number (816-444-0900)
Fax Number (816-822-1723)

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Non-Capital	Direct Cost	121,713,131	45	\$ 4,820,590	\$	4,233,787	\$ 167,684	1
2	34	Capital Building	Direct Cost	121,713,131	45	222,080		4,233,787	7,725	2
3	35	Capital Equipment	Direct Cost	121,713,131	45	40,827		4,233,787	1,420	3
4										4
5										5
6										6
7										7
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17										17
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19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 5,083,497	\$		\$ 176,829	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	WMF Huntoon		X	Mortgage	Monthly	7/1/1997	\$ 3,645,000	\$ 3,482,120		0.0850	\$ 264,705	1	
2	Cambridge Realty		X	Notes Payable	Monthly	4/12/2000	898,100	867,213		0.0825	18,225	2	
3												3	
4												4	
5												5	
	Working Capital												
6	Interest Income		X								(579)	6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 4,543,100	\$ 4,349,333			\$ 282,351	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 4,543,100	\$ 4,349,333			\$ 282,351	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																						
1. Real Estate Tax accrual used on 2004 report.				\$	109,102 1																			
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	109,102 2																			
3. Under or (over) accrual (line 2 minus line 1).				\$	3																			
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	107,000 4																			
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5																			
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6																			
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	107,000 7																			
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:		2000	155,350	8	<table><tr><td colspan="3">FOR OHF USE ONLY</td></tr><tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2004</td><td>\$</td><td>13</td></tr><tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr><tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr><tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr></table>	FOR OHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2004	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
FOR OHF USE ONLY																								
13	FROM R. E. TAX STATEMENT FOR 2004	\$	13																					
14	PLUS APPEAL COST FROM LINE 5	\$	14																					
15	LESS REFUND FROM LINE 6	\$	15																					
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																					
		2001	104,431	9																				
		2002	106,158	10																				
		2003	104,430	11																				
		2004	109,102	12																				

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bethany Health Care & Rehab Center COUNTY Dekalb

FACILITY IDPH LICENSE NUMBER 0042135

CONTACT PERSON REGARDING THIS REPORT Junior Foster, THCSLLC, Mgmt Co.

TELEPHONE 816-444-0900 FAX #: 816-822-1723

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

X. BUILDING AND GENERAL INFORMATION:

A.

Square Feet:

37,083

B.

General Construction Type:

Exterior

Brick

Frame

Number of Stories

1

C.

Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.

Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

☒

YES

☐

NO

If so, please complete the following:

1. Total Amount Incurred:

100,136

2. Number of Years Over Which it is Being Amortized:

Various

3. Current Period Amortization:

11,531

4. Dates Incurred:

Various

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	37,083	1997	\$ 303,889	1
2					2
3	TOTALS	37,083		\$ 303,889	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	90		1997	1997	\$ 3,347,204	\$ 83,680	40	\$ 83,680	\$	\$ 718,411	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1997 Additions			1997	185,048	1,498	Various	1,498		140,946	9
10	1998 Additions			1998	19,200	213	Various	213		17,511	10
11	1999 Additions			1999	16,507	1,017	Various	1,017		7,904	11
12	2000 Additions			2000	6,556	591	Various	591		3,254	12
13	2001 Additions			2001	14,405	1,282	Various	1,282		5,708	13
14	Clean and Seal parking lot			2002	2,140	268	8	268		914	14
15	Soft water mineral tank			2002	900	90	10	90		345	15
16	Compressor for A/C unit			2002	1,011	67	15	67		230	16
17	Stain Doors and Trim			2002	500	100	5	100		342	17
18	Electric heat A/C Unit			2003	1,013	101	10	101		245	18
19	Storage sheds (2)			2003	3,015	151	20	151		327	19
20	Heat lamps in shower room			2003	3,648	365	10	365		791	20
21	Hallway carpet			2003	7,802	1,560	5	1,560		4,681	21
22	Rooftop A/C unit			2004	5,175	518	10	518		819	22
23	Wanderguay system for front door			2004	1,617	162	10	162		216	23
24	Nurse station			2004	11,452	764	15	764		891	24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$3,627,193	\$92,427		\$92,427	\$	\$903,535	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 415,502	\$ 22,833	\$ 22,833	\$	Various	\$ 339,300	71
72	Current Year Purchases	5,299	745	745		Various	745	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 420,801	\$ 23,578	\$ 23,578	\$		\$ 340,045	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,351,883	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 116,005	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 116,005	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,243,580	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

YES

X

NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease

0

.

0
9. Option to Buy:

YES

X

NO

Terms: N/A

*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

X

YESNO
16. Rental Amount for movable equipment: \$2,101Description: See attached schedule
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending
11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending	Annual Rent
12. /2006	\$
13. /2007	\$
14. /2008	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?	<input type="checkbox"/> YES	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
	<input checked="" type="checkbox"/> NO	IN-HOUSE PROGRAM	IN-HOUSE PROGRAM
		IN OTHER FACILITY	IN OTHER FACILITY
		COMMUNITY COLLEGE	HOURS PER CNA
		HOURS PER CNA	

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist	10a,3	hrs	\$	4,468	\$ 252,478	\$	4,468	\$ 252,478	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		163	200,308		163	200,308	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		2,830	21,590		2,830	21,590	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	7,461	\$ 474,376	\$	7,461	\$ 474,376	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 7,970	\$	1
2	Cash-Patient Deposits	21,803		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	627,231		3
4	Supply Inventory (priced at)	17,266		4
5	Short-Term Investments			5
6	Prepaid Insurance	27,319		6
7	Other Prepaid Expenses	242,367		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due To/From LOC Lender	989,020		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,932,976	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	303,889		13
14	Buildings, at Historical Cost	3,622,604		14
15	Leasehold Improvements, at Historical Cost	4,590		15
16	Equipment, at Historical Cost	420,801		16
17	Accumulated Depreciation (book methods)	(1,243,578)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	377,038		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(58,390)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Fixed Asset Adjustment	5,000		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,431,954	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,364,930	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 196,443	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,803		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	69,148		30
31	Accrued Taxes Payable (excluding real estate taxes)	136,301		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	24,931		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	10,995		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 459,621	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	867,213		39
40	Mortgage Payable	3,482,120		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,349,333	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,808,954	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 555,976	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,364,930	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 204,566	1
2	Restatements (describe):		2
3			3
4	Restatements of Prior Year to Allow rollforward	(7,097)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 197,469	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	358,507	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 358,507	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 555,976	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Bethany Health Care & Rehab Center # 0042135 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,318,663	1
2	Discounts and Allowances for all Levels	(512,198)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,806,465	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,032,890	6
7	Oxygen	4,388	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,037,278	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,241	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	367,489	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	20,814	20
21	Other Medical Services	13,978	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 404,522	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	579	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 579	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	4,984	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,984	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,253,828	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	821,141	31
32	Health Care	2,253,871	32
33	General Administration	1,056,344	33
	B. Capital Expense		
34	Ownership	519,567	34
	C. Ancillary Expense		
35	Special Cost Centers	195,123	35
36	Provider Participation Fee	49,275	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,895,321	40
41	Income before Income Taxes (line 30 minus line 40)**	358,507	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 358,507	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	8,405	8,568	\$ 215,905	\$ 25.20	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,225	9,346	265,390	28.40	3
4	Licensed Practical Nurses	12,203	12,371	385,558	31.17	4
5	CNAs & Orderlies	48,451	48,688	561,594	11.53	5
6	CNA Trainees	4,694	4,716	60,561	12.84	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,731	4,935	56,992	11.55	10
11	Social Service Workers	3,867	3,905	59,306	15.19	11
12	Dietician	24,296	24,487	223,703	9.14	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,661	2,709	38,438	14.19	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,080	2,088	76,016	36.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,117	9,241	142,888	15.46	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,941	1,973	26,066	13.21	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	131,671	133,027	\$ 2,112,417 *	\$ 15.88	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	63	\$ 8,302	1,3	35
36	Medical Director				36
37	Medical Records Consultant	99	4,244	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	110	6,561	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	33	1,980	11,3	44
45	Social Service Consultant	32	1,908	12,3	45
46	Other(specify) <u>Housekeeping</u>	5,741	80,374	3,3	46
47	<u>Laundry</u>	3,827	53,582	4,3	47
48	<u>Admin/Gen</u>	437	37,920	21,3	48
49	TOTAL (lines 35 - 48)	10,342	\$ 194,871		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount		
Greg Nienaber	Administrator		\$ 70,838	Workers' Compensation Insurance		\$ 179,603	IDPH License Fee		\$		
				Unemployment Compensation Insurance			Advertising: Employee Recruitment		15,000		
				FICA Taxes		80,859	Health Care Worker Background Check				
				Employee Health Insurance		30,020	(Indicate # of checks performed)				
				Employee Meals			Dues & Subscriptions		7,745		
				Illinois Municipal Retirement Fund (IMRF)*			Advertising & Public Relations		32,413		
				Other Benefits		1,132					
TOTAL (agree to Schedule V, line 17, col. 1)											
(List each licensed administrator separately.)			\$ 70,838								
B. Administrative - Other											
Description			Amount								
			\$								
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ 291,614				
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**				
C. Professional Services											
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description		Amount		
Purchased services			\$ 37,920			\$	Out-of-State Travel		\$		
Management fees			210,130								
Legal fees			15,302								
Accounting fees			9,256				In-State Travel		14,574		
Data Processing fees			13,847								
Professional Services			680								
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$				
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 287,135				(agree to Sch. V, line 24, col. 8)				
							TOTAL 14,574				

*** Attach copy of IMRF notifications**

****See instructions.**

(See instructions.)

[illegible]

Facility Name & ID Number **Bethany Health Care & Rehab Center**# **0042135**Report Period Beginning: **01/01/2005**Ending: **12/31/2005****XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 9
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,441 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 49,275
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? YES Indicate the amount. \$ 2,241
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation. N/A
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? N/A
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? NO
Attach invoices and a summary of services for all architect and appraisal fees.